NUTRITION INTAKE HISTORY

Date _____

Patient Information

Patient _____

Address _____ **Apt.** _____

_____ **Age** _____ **Sex:** **M** ☐ **F** ☐

City State Zip

Home # _____ **Work #** _____ **Ext.** _____ **Birthdate** _____

Cell Phone # _____ **Patient SS#** _____

E-Mail _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ **Relationship** _____

Home Phone _____ **Work Phone** _____ **Ext.** _____

Whom may we thank for referring you? _____

Work Information

Occupation _____ **Phone** _____ **Ext.** _____

Company _____ **Address** _____

Spouse Information

Name _____ **SS#** _____ **Birthdate** _____

Occupation _____ **Employer** _____

I verify that all information within these pages is true and accurate.

_____ _____ _____

Patient's Signature Patient's Name - Please print Date

Health History

Height _____ **Weight** _____ **Number of Children** _____

Are you recovering from a cold or flu? _____ **Are you pregnant?** _____

Reason for office visit: **Date started:**

_____ _____

_____ _____

Date of last physical exam _____ **Practitioner name & contact** _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis, saliva, bone density):

_____

Outcome _____

What types of therapy have you tried for this problem(s)?

☐ Diet modification ☐ Medical ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic

☐ Acupunture ☐ Conventional drugs ☐ Physical therapy ☐ Other _____

List current health problems for which you are being treated: _____

Current medications (prescription and/or over-the-counter): _____

_____

Major hospitalizations, surgeries, injuries. Please list all procedures, complications (if any) and dates:

Year	**Surgery, illness, injury**	**Outcome**

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., job change, family status change, work related, finances, etc..) _____

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Just right **Your weight now:** _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last 3 months? ☐ Yes ☐ No

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (.e.g, fireman, farmer, miner)?

_____

☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical devices/prothetics/implants, describe: _____

Recent changes in your ability to: ☐ See ☐ Hear ☐ Taste ☐ Smell ☐ Feel hot/cold sensations

☐ Move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ☐ Sour ☐ Bitter ☐ Sweet ☐ Rich/Fatty ☐ Spicy/Pungent ☐ Salty

Strong dislike for any of the following flavors: ☐ Sour ☐ Bitter ☐ Sweet ☐ Rich/Fatty ☐ Spicy/Pungent ☐ Salty

Do you: ☐ Prefer warmth (i.e. foods, drinks, weather, ect…) ☐ Prefer cold (i.e. foods, drinks, weather, ect…) ☐ N/A

Is your sleep disturbed at the same time each night? _____ **If yes, what time?** _____

Time of day you feel the most energy or the least symptoms:		**Time of day you feel the worst or your symptoms are aggravated:**	
☐ 6:00 am - 12:00 pm	☐ 6:00 pm - 12:00 am	☐ 6:00 am - 12:00 pm	☐ 6:00 pm - 12:00 am
☐ 12:00 pm - 6:00 pm	☐ 12:00 am - 6:00 am	☐ 12:00 pm - 6:00 pm	☐ 12:00 am - 6:00 am

Do you experience any of these general symptoms EVERYDAY?

☐ Shortness of breath	☐ Nausea	☐ Fecal incontinence	☐ Bleeding	☐ Insomnia
☐ Headaches	☐ Vomiting	☐ Urinary incontinence	☐ Discharge	☐ Constipation
☐ Dizziness	☐ Diarrhea	☐ Low grade fever	☐ Itching/rash	☐ Chronic pain/inflammation

Medical History

- [ ] Arthritis
- [ ] Allergies/hay fever
- [ ] Asthma
- [ ] Alcoholism
- [ ] Alzheimer's disease
- [ ] Autoimmune disease
- [ ] Blood pressure problems
- [ ] Bronchitis
- [ ] Cancer
- [ ] Chronic fatigue syndrome
- [ ] Carpal tunnel syndrome
- [ ] Cholesterol - elevated
- [ ] Circulatory problems
- [ ] Colitis
- [ ] Dental problems
- [ ] Depression
- [ ] Diabetes
- [ ] Diverticular disease
- [ ] Drug addiction
- [ ] Eating disorder
- [ ] Epilepsy
- [ ] Emphysema
- [ ] Eyes, ears, nose, throat problems
- [ ] Environmental sensitivities
- [ ] Fibromyalgia
- [ ] Food intolerance
- [ ] Gastroesophageal reflux disease
- [ ] Genetic disorder
- [ ] Glaucoma
- [ ] Gout
- [ ] Heart disease
- [ ] Inflammatory bowel disease
- [ ] Irritable bowel syndrome
- [ ] Kidney or bladder disease
- [ ] Learning disabilities
- [ ] Liver or gallbladder disease (stones)
- [ ] Mental illness
- [ ] Migraine headaches
- [ ] Neurological problems (Parkinson's, paralysis)
- [ ] Sinus problems
- [ ] Stroke
- [ ] Thyroid trouble
- [ ] Obesity
- [ ] Osteoporosis
- [ ] Pneumonia
- [ ] Sexually transmitted disease
- [ ] Seasonal affective disorder
- [ ] Skin problems
- [ ] Tuberculosis
- [ ] Ulcer
- [ ] Urinary tract infection
- [ ] Varicose veins

Other _____

Medical (Men)

- [ ] Benign prostatic hyperplasia (BPH)
- [ ] Prostate cancer
- [ ] Decreased sex drive
- [ ] Infertility
- [ ] Sexually transmitted disease

Other _____

Medical (Women)

- [ ] Menstrual irregularities
- [ ] Endometriosis
- [ ] Infertility
- [ ] Fibrocystic breasts
- [ ] Fibroids/ovarian cysts
- [ ] Premenstrual syndrome (PMS)
- [ ] Breast cancer
- [ ] Pelvic inflammatory disease
- [ ] Vaginal infections
- [ ] Decreased sex drive
- [ ] Sexually transmitted disease

Other _____

Age of first period _____

Date of last gynecological exam _____

Mammogram [ ] + [ ] -

PAP [ ] + [ ] -

Form of birth control _____

# of children _____

# of pregnancies _____

- [ ] C-section _____
- [ ] Surgical menopause
- [ ] Menopause

Date of last menstrual cycle _____

Length of cycle _____ days

Interval between cycles _____ days

Recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Healthy History

- [ ] Arthritis
- [ ] Astma
- [ ] Alcoholism
- [ ] Alzheimer's disease
- [ ] Cancer
- [ ] Depression
- [ ] Diabetes
- [ ] Drug addiction
- [ ] Glaucoma
- [ ] Heart disease
- [ ] Infertility
- [ ] Learning disabilities
- [ ] Mental illness
- [ ] Mental retardation
- [ ] Migraine headaches
- [ ] Neurological disorders (Parkinson's, paralysis)
- [ ] Obesity
- [ ] Osteoporosis
- [ ] Stroke
- [ ] Suicide

Other _____

_____

Health Habits

- [ ] Tobacco: # per day _____
- [ ] Alcohol:

Wine: # glasses/d or wk _____

Liquor: #oz./d or wk _____

Beer: # glasses/d or wk _____

- [ ] Caffeine:

Coffee: # 6oz. Cup/day _____

Tea: # 6oz. Cup/day _____

Soda: # cans/day _____

Other _____

- [ ] Water: # glasses/day _____

Exercise

- [ ] 5 - 7 days per week
- [ ] 3 - 4 days per week
- [ ] 1 - 2 days per week
- [ ] 45 min or more duration/wk
- [ ] 30 - 45 min duration/workout
- [ ] Less than 30 min
- [ ] Walk
- [ ] Run, Jog, jump rope
- [ ] Weight-lift
- [ ] Swim
- [ ] Box
- [ ] Yoga

Other _____

Nutrition & Diet

- [ ] Mixed food diet (animal & veg)
- [ ] Vegetarian
- [ ] Vegan
- [ ] Salt restriction
- [ ] Fat restriction
- [ ] Starch/carbohydrate restriction
- [ ] Total calorie restriction

Specific food restrictions: _____

_____

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- [ ] Skip breakfast
- [ ] Two meals/day
- [ ] One meal/day
- [ ] Graze (small frequent meals)
- [ ] Food rotation
- [ ] Eat constantly (hungry or not)
- [ ] Eat on the run
- [ ] Add salt to food

Current Supplements

- [ ] Multivitamin/mineral
- [ ] Vitamin C
- [ ] Vitamin E
- [ ] EPA/DHA
- [ ] Evening primrose/GLA
- [ ] Calcium, source _____
- [ ] Magnesium
- [ ] Zinc
- [ ] Minerals, describe _____
- [ ] Friendly flora (acidophilus)
- [ ] Digestive enzymes
- [ ] Amino acids
- [ ] CoQ10
- [ ] Antioxidants (eg, lutein, resveratrol, etc.)
- [ ] Herbs - teas
- [ ] Herbs - extracts
- [ ] Chinese herbs
- [ ] Ayurvedic herbs
- [ ] Homeopathy
- [ ] Bach flowers
- [ ] Protein shakes
- [ ] Superfoods (eg. Phytonutrient blends)
- [ ] Liquid meals

Other_____

Would you like to:

- [ ] Have more energy
- [ ] Be stronger
- [ ] Have more endurance
- [ ] Increase your sex drive
- [ ] Be thinner
- [ ] Be more muscular
- [ ] Improve your complexion
- [ ] Have stronger nails
- [ ] Have healthier hair
- [ ] Be less moody
- [ ] Be less depressed
- [ ] Feel more motivated
- [ ] Be more organized
- [ ] Thisnk more clearly; be more focused
- [ ] Improve memory
- [ ] Do better on tests
- [ ] Not be dependent on over-the-counter meds like aspirin, ibuprofen, sleeping aids, etc
- [ ] Stop using laxatives or stool softeners
- [ ] Be free of pain
- [ ] Sleep better
- [ ] Have agreeable breath
- [ ] Have agreeable body odor
- [ ] Have stronger teeth
- [ ] Get less colds and flus
- [ ] Get rid of your allergies
- [ ] Reduce your risk of inherited disease tendencies (eg. cancer, heart disease, etc..)